Kentucky Teachers' Retirement System

479 Versailles Rd
Frankfort KY 40601
Phone: (502) 848-8500 or 1-800-618-1687
Fax: (502) 573-0199
www.ktrs.ky.gov

MEDICARE INFORMATION FORM

You must be enrolled in Medicare Part B to be eligible for the KTRS Medicare Eligible Health Plan (MEHP). Complete this form by copying information exactly from your red, white & blue Medicare card and return it to KTRS to enroll in the MEHP. If you have applied for Medicare, but have not received your card you must contact your local Social Security office to request your Medicare number and effective dates of Parts A and B. Then, upon receiving your Medicare card, you must forward a copy to KTRS at the above address. Also, you must notify KTRS in the event your Medicare number changes due to the death of a spouse, marriage, or divorce.

If proof of your Medicare Part B coverage is not provided to this office before the MEHP enrollment date, you will not be enrolled in coverage through KTRS. Also, now or in the future, if you are enrolled in another Medicare Advantage plan and/or a Medicare Part D prescription drug plan (outside of KTRS) or your Part B coverage terminates, your KTRS MEHP will be terminated.

You could be eligible to enroll during any open enrollment period by completing an MEHP Enrollment Form, providing proof of Medicare Part B coverage, and submitting the paperwork to this office no later than December 31 for an effective date of January 1. Outside of open enrollment, you will be eligible to enroll if a qualifying event occurs. Obtaining Medicare Part B is considered a qualifying event and you will only have 30 days from the event date to enroll. If you experience a qualifying event, contact this office to request an MEHP Enrollment Form.

SECTION 1 - RETIREE INFORMATION

RETIREE'S NAME: _____ Email address: _____

Phone Number:_____

SOCIAL SECURITY NUMBER:_____

MEDICARE CLAIM NUMBER: _____

HOSPITAL (PART A) EFFECTIVE DATE: _____

MEDICAL (PART B) EFFECTIVE DATE: _____

SECTION 2 - SPOUSE INFORMATION, if enrolled in KTRS medical coverage

SPOUSE'S NAME: _____ Email address: _____

Phone Number:_____

SOCIAL SECURITY NUMBER:_____

MEDICARE CLAIM NUMBER: _____

HOSPITAL (PART A) EFFECTIVE DATE: _____

MEDICAL (PART B) EFFECTIVE DATE: _____